APR 12 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10477
Do not use this space.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH
(a) County Callaway — Registration District No. 104
(b) Township or (c) City Fulton — Primary Registration District No. 3008 — Registered No. 95
(d) Street No. State Hospital # 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 2 5/12 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Leona C. Jacquin
(a) Residence, No. Gasconade, Mo. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS	
3. SEX	Female
4. COLOR OR RACE	White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	—
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)	July, 30 1915
7. AGE	Years 24, Months 8, Days 0; If LESS than 1 day, ...hrs. or ......min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	None
9. Industry or business in which work was done, as saw mill, bank, etc.	—
10. Date deceased last worked at this occupation (month and year)	—
11. Total time (years) spent in this occupation	—
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Berger, Mo.
FATHER 13. NAME	Edmund Jacquin
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Frenchville, Pa.
MOTHER 15. MAIDEN NAME	Paulina Hug
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Hermon, Mo.
17. INFORMANT (ADDRESS)	Hospital Records.
18. BURIAL, CREMATION, OR REMOVAL PLACE	Herman, Mo. DATE March 31, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS)	Hugo L Blumer, Hermann Mo
20. FILED	April 1, 1940 R. N. Crews, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 30, 1940

22. I HEREBY CERTIFY, That I attended deceased from March 8, 1940, to March 30, 1940
I last saw her alive on March 30, 1940. Death is said to have occurred on the date stated above, at 11:40 A m.
The principal cause of death and related causes of importance were as follows:

Cause	Date of onset
Syphilitic Meningo-Encephalitis.	indef.

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Other contributory causes of importance:
Decubitus Ulcers with secondary infection

Name of operation ...... Date of ......
What test confirmed diagnosis? Spinal, Wassermann, Colloidal Gold Curve. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No. Date of injury ......, 19......
Where did injury occur? ......
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ......
Nature of injury ......

24. Was disease or injury in any way related to occupation of deceased? ......
If so, specify ......
(Signed) Forrest Thomas, M. D.
(Address) State Hospital No. 1, Fulton Mo

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

50M-9-19-38 I X16505

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.